

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 06-14-04.

The IRO reviewed neuromuscular re-education, electric stimulation, myofascial release, therapeutic exercises and office visits rendered from 07-15-03 through 07-30-03 that were denied based upon "U".

The IRO determined that neuromuscular re-education **was not** medically necessary. The IRO determined that the electrical stimulation, myofascial release, therapeutic exercises and office visits **were** medically necessary.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the **majority** of issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20-days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 08-10-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

CPT code 97110 for dates of service 07-08-03 and 07-09-03 denied with denial code "F". Recent review of disputes involving CPT code 97110 by the Medical Dispute Resolution section as well as analysis from recent decisions of the State Office of Administrative Hearings indicate overall deficiencies in the adequacy of the documentation of this code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what

constitutes "one-on-one". Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division (MRD) has reviewed the matters in light of the Commission requirements for proper documentation.

The MRD declines to order payment for code 97110.

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this order. This Decision is applicable for dates of service 07-15-03 through 07-30-03 in this dispute.

This Findings and Decision and Order are hereby issued this 7th day of October 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

August 5, 2004

Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

Re: Medical Dispute Resolution
MDR #: M5-04-3487-01
TWCC#:
Injured Employee:
DOI:
SS#:
IRO Certificate No.: 5055

Dear

____ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ____ reviewed relevant medical records, any documents provided by the parties referenced above, and any

documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of ____ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine and is currently on the TWCC Approved Doctor List.

REVIEWER'S REPORT

Information Provided for Review:

TWCC-60, Table of Disputed Services, EOB's

Information provided by Requestor: correspondence, office notes, physical therapy notes, operative and radiology reports.

Information provided by Respondent: designated doctor exam.

Clinical History:

Patient is a 35-year-old male who, on ____, injured his lower back while on his job. He felt immediate pain in his lower back, but continued working hoping it would go away. When it did not, he presented himself to a doctor of chiropractic who began his treatment. After a short trial of conservative care and physical therapy, an MRI revealed a significant disc herniation and the patient underwent lumbar laminectomy at L4-5 and at L5-S1 on 05/07/03. The services in dispute in this case concern his post-surgical physical therapy.

Disputed Services:

Neuromuscular re-education, electric stimulation, myofascial release, therapeutic exercises, and office visits during the period of 07/15/03 through 07/30/03.

Decision:

The reviewer partially disagrees with the determination of the insurance carrier as follows during the period of 07/15/03 through 07/30/03:

- Electrical stimulation, myofascial release, therapeutic exercises and office visits were medically necessary.
- Neuromuscular re-education was not medically necessary.

Rationale:

The documentation submitted well established the medical necessity for physical therapy since the injured worker sustained a significant injury and subsequently underwent spinal surgery. So, the office visits with manipulation (99213), electrical stimulation (97032), myofascial release (97250), and the therapeutic exercises (97110) were medically necessary.

However, the diagnosis and physical examination findings did not support the medical necessity of the neuromuscular reeducation (97112). In fact, the examination report reported that the “sensory, cerebellar, deep tendon reflexes and gait examination were within normal limits.” In addition, the records were devoid of any documentation supporting any proprioceptive disturbances or pathology.

Sincerely,